VICTOR VALLEY
Community Hospital

October 15, 1997

David Werdeger, M.D., MPH
Director
Health Policy and Planning Division
Office of Statewide Health Planning and Development
1600 Ninth Street, Room 400
Sacramento, CA 95814

**re**: California Hospital Outcomes Project: Acute Myocardial Infarction

Dear Dr. Werdeger:

Victor Valley Community Hospital's response to California's Hospital Outcomes Project, Acute Myocardial Infarction, directs its attention at several key issues surrounding the study.

The 1991-1993 time frame for Victor Valley Community Hospital marked a distinct period in the treatment of Cardiac patients. Prior to that, the Hospital's large, semi-rural, catchment area required all patients needing invasive cardiac procedures to be transported over 50-70 miles. The establishment of our Cardiac Catheterization and Open Heart Surgical Program in November, 1990, ultimately resulting in a profound, broad based improvement of professional strategies and outcomes. Cardiac patients on the High Desert were now admitted to our service. From the end of 1991 forward, our Quality Improvement efforts successfully improved "time to treatment," and thus, reduced in-hospital mortality. These efforts resulted in 1993's "outcomes data," placing the hospital in the "significantly better than expected" category. We are extremely proud of that result and are confident our continued efforts at performance improvement will reflect overall high quality of care.

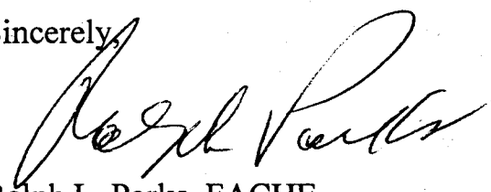
Our success in this quality improvement effort is further dramatized when effects of demographics and comorbidities are explored. The hospital is a federally

identified "Disproportionate Share" facility for both Medi-Care and Medi-Cal. Our patients are elderly, very sick, and represent clearly, an underserved population. Generally they are sicker than those treated by the other hospitals in the area. Furthermore, the majority of mortality patients in all three years of the OSHPD study exceeded 70 years of age.

Finally, the utilization of ICD-9-CM codes as a primary data collection source adds measurably to the confusion surrounding the results. The lack of standardization of coding procedures and the variation of coding practices imposes an enormous burden on the conclusions. It clearly negates the uniformity sought by risk adjusting the information. Certainly, the omission of "Do Not Resuscitate(DNR)" orders and the inability to capture this statistic has been already identified by OSHPD as a significant weakness in their study. The undercoding possibility leaves the outcome data fraught with potential error, especially when data is five years old, and the overwhelming consensus agrees that the quality of coding practices between facilities is based on vague coding guidelines and reimbursement-driven coding practices. As such, a single or a few outcome indicators may not truly reflect a hospital's quality of care and may only serve to jeopardize reliable, professional discovery.

We are proud of the quality care given at Victor Valley Community Hospital and support all efforts directed at accurately identifying quality medical care.

Sincerely,



Ralph L. Parks, FACHE
CEO/Administrator



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